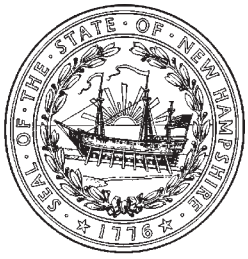

New Hampshire Board of Medicine
2 Industrial Park Drive, Suite 8, Concord, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
Web Site: www.state.nh.us/medicine

Application for Licensure

Instructions
Application
and
Forms

NOTICE!
To All Applicants for Licensure in New Hampshire

All applicants for licensure in New Hampshire are required to submit their background credentials to the Federation Credentials Verification Service (FCVS). FCVS is a service of the Federation of State Medical Boards and was created to help simplify the licensure process for physicians (both MD's and DO's).

FCVS provides a permanent central depository for documents which represent the core credentials of any physician. FCVS will conduct a primary source verification of those documents at the time they are submitted, and the physician will not be required to re-verify that information even if he or she moves to another state. Currently, 59 state medical boards accept FCVS documents in lieu of the applicant providing new original source documents. New Hampshire and 8 other state medical boards require all applicants to use FCVS for verification of their credentials.

Enclosed, or on our website, you will find 2 separate application forms. You should first complete the FCVS application form and forward that directly to FCVS at the address provided within that application. You should expect the verification process to take a minimum of eight weeks.

Be sure to read the instructions carefully and fill out the application completely. Do not omit any information. If you have questions about the FCVS application, you may contact them by calling 1-888-ASK-FCVS. Do not call the Board's office for questions regarding the FCVS application. When all documents have been sufficiently verified, FCVS will forward your credentials package to the Board.

The next step in the application process will be to complete the Board's Application for Licensure. You may submit your Board Application at the same time that you submit your FCVS application. Processing will occur simultaneously. The Board conducts an independent background investigation. The sooner we receive your application, the sooner we can begin processing that background investigation.

We have taken every precaution to avoid asking for repetitive information; however, you must complete every question on the application. If the question does not apply to you, simply write N/A.

The Board believes that FCVS offers a tremendous opportunity for physicians and state medical boards to improve the burdensome and duplicative process currently in place for state by state licensure. By eliminating the re-verification of documents that never change, physicians will benefit from a shortened credentialing process when they relocate or affiliate within other states. Additionally, the Board has incorporated the Common License Application-Form (CLA-F) into its application. This form will make it easier for physicians to apply for licensure in states that utilize this form (CLA-F). New Hampshire is one of the first states to utilize this form, so please contact the other boards to which you want to apply to find out if they have incorporated the CLA-F into their state application.

The Board reviews applications on the first Wednesday of each month. All applications must be complete before they are submitted to the Board for consideration. The agenda for Board consideration is closed at 12:00 P.M. on the day before the Board meets. Applications completed after 12:00 P.M. will be placed on the next month's agenda. Faxed materials are not acceptable.

General Information

The licensure process in the State of New Hampshire is conducted jointly by the New Hampshire Board of Medicine (Board) and the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). All licensure applicants must complete and submit a Board application **and** a separate FCVS application (enclosed).

FCVS Application Process

You must submit an FCVS application to have your "core" credentials verified directly to the Federation's national office (Texas). This verification process is conducted separately and independently by FCVS in accordance with established polices and procedures set forth by the Board. Because the verification process is the most time-consuming task, it is recommended that you submit this application as soon as possible. You will deal directly with FCVS for all aspects of this verification. **Do not contact the Board about your FCVS application.**

FCVS will verify your applicable credentials from the original, primary source in the following categories (some may not apply):

- Medical Education
- Postgraduate Training
- Clinical Clerkships/Fifth Pathway
- Examination History
- Board Action History
- ECFMG Certification
- Identity

When all information is received and reviewed for accuracy, FCVS forwards a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials directly to the Board. Refer to the enclosed gray application titled "FCVS Instructions, Application and Forms" to complete this credentials verification process. For more information about the FCVS process, or if you need assistance completing the FCVS application, call toll-free 1-888-ASK-FCVS (1-888-275-3287).

Board Application Process

In addition to the FCVS application and process, you must submit additional information directly to the Board. The Board will use this information, along with the FCVS Profile, to assess your qualifications for licensure. Please allow a minimum of eight weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional two or three months for all pertinent documentation to be received.

The Board meets the first Wednesday of each month. Only applications that are complete, including all outside verifications, will be forwarded to the Board for review. Licenses will be issued within 7-10 working days following the Board meeting and are mailed to the address furnished in your application. **You are responsible for notifying the Board office, in writing, if your address changes in the interim.**

Temporary License Application Process

Since the FCVS application process is fairly lengthy, and unless you already have an FCVS profile, you may want to apply for a temporary license in New Hampshire. A temporary license, if issued, is valid for only six months and requires you to provide a completed application, with the exception of the FCVS application, and additional information as follows:

(1) Evidence of qualifications as follows:
   a. Proof of a full, unrestricted medical license in another state received directly from the state licensing authority; or
   b. Certified copies of medical degree diploma, proof of 2 years of postgraduate training which meet the requirements of Med 302.01, and proof that you have passed one of the licensure examinations listed under Med 303.01;

(2) Proof that you have applied to the FCVS with full intent to complete the FCVS process. The Board will accept a letter from you verifying this information; and

(3) The temporary license fee of $50.00. Make check payable to TREASURER, STATE OF NEW HAMPSHIRE.

**Please continue to review the remaining portions of this application packet (on white paper) for instructions and other materials necessary to completing the Board application. If you have questions about this application process, or would like to check on the status of your Board application, please call the Board at (603) 271-1203.

Instructions for Completing the Board Application

Licensure Requirements

Before completing the application process, please review the following requirements for licensure in New Hampshire:

- Obtained the M.D./D.O. degree or its equivalent as determined by the Board;
- Completed at least 2 years of postgraduate training in the U.S. or Canada approved by the Board, or its equivalent as determined by the Board;
- Successfully passed a national licensing examination sequence (or its acceptable hybrid combination) as approved by the Board on each examination, including:
    - National Board of Medical Examiners (NBME) Part I, II and III;
    - Pre-1985 FLEX or FLEX Component 1 and 2;
    - USMLE Step 1, 2 and 3;
    - NBOME Part I, II and III (or COMLEX);
    - Licentiate of the Medical Council of Canada (LMCC).

If you do not meet, or have questions about these requirements, please contact the Board prior to submitting your application.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ballpoint pen. Board staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.
4. All documents you submit must be originals, signed on letterhead unless notarized copies are specifically authorized.
5. You will receive an acknowledgment letter once your application has been received. This letter will advise you of what information, if any, is outstanding at that time. If you do not receive an acknowledgment letter within 30 days, please contact the Board between 8:00 A.M. and 4:00 P.M. EST.

Completing your Application

1. Complete the Board Application (pages 1-20). You must respond to all components of the application. **See "Licensure Requirements" above**.

Make a check or postal or express money order (in U.S. funds only) for the application fee of **$250.00** payable to: Treasurer, State of New Hampshire and staple it to the upper left-hand corner of the first page of the application. This application fee is NON-REFUNDABLE. [NOTE: This is the Board application fee. The FCVS verification fee is an additional and separate fee paid directly to FCVS.]
(An additional $50.00 fee is required if requesting a temporary license)

2. Complete page 10, "Affidavit and Authorization For Release of Information." The affidavit must be signed in the presence of a notary and must have a 2"x2" recent "passport" photograph of yourself securely affixed to the form. [NOTE: The FCVS application also requires a separate Affidavit that must be notarized. You may wish to have both

forms notarized at the same time. Be certain to submit the correct form to the correct agency.]

3. Complete page 12, "Malpractice Liability Claims Information," if applicable. You must use this form to report all claims or suits for medical malpractice made against you in the last ten years. The report should be completed in its entirety. Make additional copies of this page as necessary for multiple claims.
4. Obtain a total of four (4) letters of reference attesting to your moral character and professional abilities. These letters must be obtained from the following: the chief of staff (ref. 1) and hospital administrator (ref. 2) in a hospital where you presently hold staff privileges (if no staff privileges are presently held, letters of recommendation shall be submitted by 2 other practicing medical doctors who hold hospital staff privileges); and two (2) additional letters of reference from practicing physicians. Reference letters must be originals submitted on letterhead. References may be submitted by the applicant or by the physician providing the reference.
5. Submit a notarized copy of your American Board of Medical Specialty Certificate(s), if applicable.
6. Submit your curriculum vitae.
7. Submit a notarized copy of your current Drug Enforcement Administration (DEA) certificate.
8. Obtain verification from all states where you hold, or have ever held, a license to practice medicine. To obtain this verification, you must mail page 11, "Licensure Verification Form," to each licensing authority in which you are/were licensed. Be certain to sign and complete the identifying information on each form. These verifications must be received directly from the licensing authority. You may obtain the mailing address of all 69 medical licensing authorities at the Federation of State Medical Boards' website at www.fsmb.org, or by calling the Board in question. Most states charge a fee for verification of licensure. To save time, you should check with the state board before submitting your request. Please do not contact the New Hampshire Board for mailing addresses of other licensing authorities.
9. Complete the "Addendum to Application" (Addendum Pages 1-2).
10. Prepare all application materials as instructed. Do not submit applications without all applicable information and documentation. Mail your application to:

Board of Medicine
2 Industrial Park Drive, Suite 8
Concord, New Hampshire, 03301-8520

Other Information

Your application process is not considered complete until your Board application, licensure verification(s), and FCVS Physician Information Profile are received in a manner satisfactory to the Board. The Board will not accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed at the first available Board meeting. Please allow 7-10 working days following the Board meeting for your license to be mailed to you.

Note: Do NOT make commitments to start practicing medicine in New Hampshire until you have been issued a license.

Application for Physician Licensure Instructions

Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. There are two different checklists below; one when you are using the Federation Credentials Verification Service and one when you are not using FCVS. Please use the checklist that applies to you.

	Not Using FCVS	Using FCVS
Completed Application	☐	☐
State Licensure Verification form sent to the Board from all states in which you have ever held any healthcare license	☐	☐
Enclose the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	☐	☐
Notarized copy of birth certificate or current, valid passport	☐	Not Applicable
Medical Education Verification form sent to the Board by all medical schools attended – include a copy of your diploma (must be sealed by your school)	☐	Not Applicable
Medical school transcripts sent to the Board by your medical school	☐	Not Applicable
Fifth Pathway (if applicable) form sent to the Board from the medical school and institution – include a copy of your diploma (must be sealed by your school)	☐	Not Applicable
Postgraduate Training Verification form sent to the Board from all programs you attended	☐	Not Applicable
Enclose a copy of your postgraduate training certificate with this application when submitting it to the Board	☐	Not Applicable
Examination transcripts sent to the Board	☐	Not Applicable
ECFMG (if applicable) Status Report sent to the Board	☐	Not Applicable

It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.

Application for Physician Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name _____

First Name _____

Middle Name _____

Suffix _____

Maiden Name _____

M.D. ☐ D.O. ☐

_____

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

Practice Address

☐ Public Access

☐ Mailing

Street _____

City _____ State _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone _____

Home Address

☐ Public Access

☐ Mailing

Street _____

City _____ State _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone _____

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

/ /

Date of Birth (mm/dd/yyyy) | Birth City | Birth State | Birth Country

Gender | Social Security Number | Are you a U.S. Citizen? ☐ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School (attach additional pages if necessary)

1. School Name

Address

City

State

ZIP Code

Country

Attendance Dates (From – To)

Graduation Date

Degree

2. School Name

Address

City

State

ZIP Code

Country

Attendance Dates (From – To)

Graduation Date

Degree

Applicant Name: Date:

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name _____

Address _____

City _____

State _____

ZIP Code _____

Country _____

Attendance Dates (From - To) _____

Graduation Date _____

Degree _____

Institution name where rotations performed _____

Address _____

City _____

State _____

ZIP Code _____

Country _____

Attendance Dates (From - To) _____

Certification Date _____

Applicant Name: _____ Date: _____

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name _____

Hospital Address _____

City _____

State _____

ZIP Code _____

Country _____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: _____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

2.Hospital Name _____

Hospital Address _____

City _____

State _____

ZIP Code _____

Country _____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: _____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

Applicant Name: _____ Date: _____

6. Postgraduate Training (continued)

3.Hospital Name_____

Hospital Address_____

City_____

State_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty:_____

From: ____/____ To: ____/____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

4.Hospital Name_____

Hospital Address_____

City_____

State_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty:_____

From: ____/____ To: ____/____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

Applicant Name: _____ Date: _____

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination		Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
State Board Exam	_____ State	_____	☐ P	☐ F	_____
FLEX Pre-1985		_____	☐ P	☐ F	_____
FLEX Component 1		_____	☐ P	☐ F	_____
LEX Component 2		_____	☐ P	☐ F	_____
MCC – Single		_____	☐ P	☐ F	_____
MCC – Part I		_____	☐ P	☐ F	_____
LMCC – Part II		_____	☐ P	☐ F	_____
NBME Part I		_____	☐ P	☐ F	_____
NBME Part II		_____	☐ P	☐ F	_____
NBME Part III		_____	☐ P	☐ F	_____
NBOME Part I		_____	☐ P	☐ F	_____
NBOME Part II		_____	☐ P	☐ F	_____
NBOME Part III		_____	☐ P	☐ F	_____
SPEX		_____	☐ P	☐ F	_____
COMVEX		_____	☐ P	☐ F	_____
COMLEX		_____	☐ P	☐ F	_____
USMLE Step I		_____	☐ P	☐ F	_____
USMLE Step II		_____	☐ P	☐ F	_____
USMLE Step III		_____	☐ P	☐ F	_____

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number _____ Issue Date _____ Valid Through Date _____

9. State or Professional Licensure: You must complete the attached "Licensure Verification" form and forward it to all states in which you have held any healthcare license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure – MD or DO only – attach additional pages if necessary

1. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)
2. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)
3. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)
4. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)
5. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)
6. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)
7. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)
8. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)
9. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)
10. State _____ Type _____ License Number _____ Status _____ Issue Date _____
(MD, DO, etc)

Applicant Name: _____ Date: _____

All Other Healthcare Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State _____ Type _____ License Number _____ Status _____ Issue Date _____

10. Chronology of Activities: Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school to the present date, leaving no time period unaccounted for in your resume. Use an additional page to account for non-professional activities and any other gaps in time between professional experiences, including military duty.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: To:	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
2. From: To:	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

Dates: From/To	Practice/Employment
3. From: To:	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
4. From: To:	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
5. From: To:	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
6. From: To:	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

Applicant Photograph

Securely tape or glue in this sqaure a current front-view 2" x 2" passport-type color photograph of yourself.

_____
Applicant's Signature (must be signed in the presence of a notary)

_____
Applicant's Printed Last Name

_____
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

_____
Date of Signature

NOTARY

Dated_____ Signed_____

State of_____ County of _____

SUBSCRIBED AND SWORN TO before me this_____ day of, _____ 20____.

My commission expires:_____ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: _____ Date: _____

Licensure Verification Form
(Copy this form for multiple licenses)

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board:

To be completed by applicant

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____ Social Security Number: _____ License Number: _____
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.

Signature of Applicant _____ Date _____

Board Name: _____

Address: _____
Street City State ZIP Code

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License Number: _____ Issue Date: _____

Is this license current? ☐ Yes ☐ No If No, please explain: _____

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: _____

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended, or in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: _____

Board Authorized Signature: _____

Affix Board Seal Here

Title: _____

Date: _____

Please return this form to the Board listed at the top of this form.

Form #2

Malpractice Liability Claims Information

(Copy this form to report multiple claims)

Name of Patient Involved: _____

In which state did the action take place? _____ Which court? _____

Case number _____

Current status of this claim: _____

☐ Open (pending) ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Other _____

Amount of judgment or settlement $ _____ Amount paid on your behalf $ _____

Month and Year of Event precipitating claim: _____

Month and Year of Lawsuit: _____

Insurance Carrier at Time: _____

What is/ was your status? ☐ Primary Defendant ☐ Co-Defendant ☐ Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Form #3

Medical School Verification – Page 1 of 4

(Copy this form for multiple schools)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

Section 1: Applicant Information

Last Name: _____ First Name: _____ Middle Name:_____

Name if different when diploma awarded:_____

Social Security Number: _____ Date of Birth:_____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Medical School below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature_____ Date _____

Section 2: Instructions to the Dean or designated official of medical school

Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an official copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Board Name:_____

Address _____City _____ State_____ ZIP Code _____

Medical School Verification – Page 2 of 4
(Copy this form for multiple schools)

Section 3: Medical School Verification

Medical School Name:_____

School name if different when the above applicant attended:_____

Medical School Address:_____

Street City State ZIP Code

Hours of undergraduate education required for admission into your school: _____

Applicant's Attendance Dates: From_____ To_____ Graduation Date: _____ Degree:_____

(Indicate N/A if not applicable) (Indicate N/A if not applicable)

Total weeks of education applicant attended your school: _____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print name:_____

AFFIX INSTITUTIONAL SEAL HERE Title:_____

(If no seal is available, this form must be notarized) Date:_____

Phone number:_____ Fax: _____

E-mail:_____

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

Medical School Verification – Page 3 of 4
(Copy this form for multiple schools)

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response ☐ YES ☐ NO

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response ☐ YES ☐ NO

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

		From Mo/Yr	To Mo/Yr
☐	Academic Probation		
☐	Probation for unprofessional conduct/behavioral		
☐	Probation for other reason		
	Please specify reason:		

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

Medical School Verification – Page 4 of 4

(Copy this form for multiple schools)

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Postgraduate Training Verification - Page 1 of 3

(Copy this form for multiple programs)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your training program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name:_____

First Name:_____

Middle Name:_____

Name if different when diploma awarded:_____

Social Security Number: _____

Date of Birth:_____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official of POSTGRADUATE TRAINING PROGRAM.

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:

Board Name:_____

Address _____

City _____

State_____

ZIP Code_____

Postgraduate Training Verification - Page 2 of 3

(Copy this form for multiple programs)

Section 3: Postgraduate Training Verification

Institution Name:_____

Institution Address:_____

Street_____

City_____

State_____

ZIP Code_____

Affiliated Medical School Name: _____

Program Type/Specialty: _____

Postgraduate Year:_____

Internship Residency Fellowship Research Chief Resident Other _____

From Date: _____/_____/_____ To Date: _____/_____/_____

Successfully Completed?: Yes No In Progress

(The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her training?	Yes ☐	No ☐
Was this individual ever placed on probation?	Yes ☐	No ☐
Was this individual ever disciplined or placed under investigation?	Yes ☐	No ☐
Were any negative reports ever filed by instructors?	Yes ☐	No ☐
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes ☐	No ☐

Please explain any “Yes” response from above (attach additional pages if necessary):_____

Postgraduate Training Verification - Page 3 of 3

(Copy this form for multiple programs)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print name: _____

Title:_____

Date:_____

Phone number:_____

Fax: _____

E-mail:_____

AFFIX INSTITUTIONAL SEAL HERE (If no seal is available, this form must be notarized)

If you completed Section 5 of the application, you must complete this form

Fifth Pathway Verification

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to the director of your 5th Pathway Program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name:_____

First Name:_____ Middle Name: _____

Name if different when diploma awarded:_____

Social Security Number:_____

Date of Birth:_____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:

Board Name:_____

Address _____

City _____

State_____ ZIP Code _____

Section 3: Medical School Verification

Medical School Name:_____

School name if different when the above applicant attended: _____

Applicant's Attendance Dates: From_____ To _____ Program Completion Date: _____
(Indicate N/A if not applicable)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print name: _____

AFFIX INSTITUTIONAL SEAL HERE Title: _____

Date:_____

Phone number: _____

Addendum to Application

Please answer the following questions. **If you answer "yes" to any of these questions, please explain on the reverse side of this sheet, or attach an additional 8 1/2" x 11" sheet(s) if necessary.**

	YES	NO
1. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates).	____	____
2. Have you ever, for any reason, lost American Specialty Board Certification?	____	____
3. Have you been denied required recertification by any specialty boards? (If yes, list each boards and dates denied).	____	____
4. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, indicate how many).	____	____
5. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?	____	____
6. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school?	____	____
7. Have you ever failed any national medical licensure examination, or any part of that examination, state board examination or failed to gain certification from the National Board of Medical Examiners? You must report all exam failures, even if you later passed the examination. (This does not include specialty board certification examinations.)	____	____
8. Have you ever failed a foreign licensing or certification examination?	____	____
9. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	____	____
10. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action?	____	____
11. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?	____	____

	YES	NO
12. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action?	____	____
13 .Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies?	____	____
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been charged, investigated or warned by a state or federal agency based on controlled substance issues?	____	____
15. Have you ever had any physical, emotional or mental illness which has impaired or would be likely to impair your ability to practice medicine?	____	____
16. Are you now, or have you, during the past five years, been dependent upon alcohol or habituating drugs or undergone treatment for such?	____	____

Anticipated Practice Location(s) (if known):

_____

_____

_____

_____

For Board Use Only:

Application Received:_____ , 20 _____ Fee Paid: _____ Check#: _____

License Number: _____ Date of Issue: _____